ARTS
Addiction and Recovery Treatment Services

The Centers for Medicare and Medicaid Services:
SUPPORT Act Section 1003 Grant

SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: —9 SUD TREATMENT BASICS

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JANUARY 12, 2021

Department of Medical Assistance Services

Welcome & Meeting Information

- WebEx participants are muted
  - Please use Q&A feature for questions
  - Please use chat feature for technical issues
- Focus of today's presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions
- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – www.dmas.virginia.gov/#/ARTS
- We are unable to offer CEUs for this webinar series

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Disclaimer

2021

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,836,765 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. https://redcap.vcu.edu/surveys/?s=C8HERT9N3P

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!

Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - http://dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/lay-rescuer-training
  - https://getnaloxonenow.org/
    - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
  - https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422
  - Available only to Virginia residents, intramuscular administration

Website Update

DMAS Home Page: https://www.dmas.virginia.gov/#/index

ARTS Home Page: https://www.dmas.virginia.gov/#/arts

SUPPORT Act Grant Website - https://www.dmas.virginia.gov/#/artssupport

SUPPORT Act Grant Overview

The Virginia Department of Medical Assistance Services (DMAS) was awarded the Centers for Medicare & Medicaid Services SUPPORT Act Section 1003 Grant in September 2019. The purpose of this grant is to decrease substance use disorder (SUD) provider workforce barriers and increase the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services.

Grant Goals

- Learn from Addiction and Recovery Treatment Services (ARTS) program
- Decrease barriers to enter workforce
- Focus on specific subpopulations: justice-involved members and pregnant and parenting members
- Maintain our core values: person-centered, strengths-based, recovery-oriented

Grant Components

- Needs assessment
- Strengths-based assessment
- Activities to increase provider capacity

Period of Performance

September 2019 - September 2021

Grant Email

SUPPORTgrant@dmas.virginia.gov

Information

- Virginia Medicaid Agency Awarded Federal Grant to Combat Opioid Crisis [pdf]
- Summary of Virginia's SUPPORT Act Goals and Activities [pdf]
- Accessibility Notice [pdf]

Resources

- UCSF National Clinician Consultation Center Warmline [pdf]
- COVID-19 Resource Library [pdf]

Monthly Stakeholder Meetings

- October 2020 [pdf]
- September 2020 [pdf]
- August 2020 [pdf]
- July 2020 [pdf]
- June 2020 [pdf]
- May 2020 [pdf]
- April 2020 [pdf]
- March 2020 [pdf]

Fall 2020 Webinars

- Video: How to Set Up a Preferred OBOT Webinar
- Slide Deck: How to Set Up a Preferred OBOT Webinar [pdf]
- Video: Hepatitis C Treatment Webinar
- Slide Deck: Hepatitis C Treatment Webinar [pdf]
- Fall 2020 Webinar Schedule [pdf]

SUPPORT 101 Webinars

- Session Twenty: "Novel" Substances [pdf]
- Session Nineteen: SUD & LGBTQ+ Clients [pdf]
- Session Eighteen: SUD & Legally-Involved Clients [pdf]
- Session Seventeen: Alcohol & Cannabis [pdf]
- Session Sixteen: SUD and The Family [pdf]
- Session Fifteen: SUD & Cultural Humility [pdf]
- Session Fourteen: Addressing SUD Stigma and Building Provider Empathy [pdf]
- Session Thirteen: Group Therapy Skills [pdf]
- Session Twelve: Individual Therapy Skills [pdf]
- Session Eleven: Co-Occurring Disorders [pdf]
- Session Ten: Screening and Assessment for SUD [pdf]
- Session Nine: SUD Treatment Introduction [pdf]
- Session Eight: Opioids and Stimulants Overview [pdf]
- Session Seven: Substance Use Disorders (SUD) Overview [pdf]
- Session Six: Providing Trauma-Informed Care [pdf]
- Session Five: Withdrawal Syndromes [pdf]
- Session Four: Crisis and Deescalation [pdf]
- Session Three: Suicide Assessment and Screening [pdf]
- Session Two: Client Engagement [pdf]
- Session One: Tele-Behavioral Health in the time of COVID-19 [pdf]
- Dr. Mishka Terplan - Pregnant and Postpartum Care for SUD during COVID-19 [pdf]
- Dr. Mishka Terplan - HIV and HCV Updates [pdf]
- Dr. Mishka Terplan - Chronic Pain and Addiction Treatment [pdf]

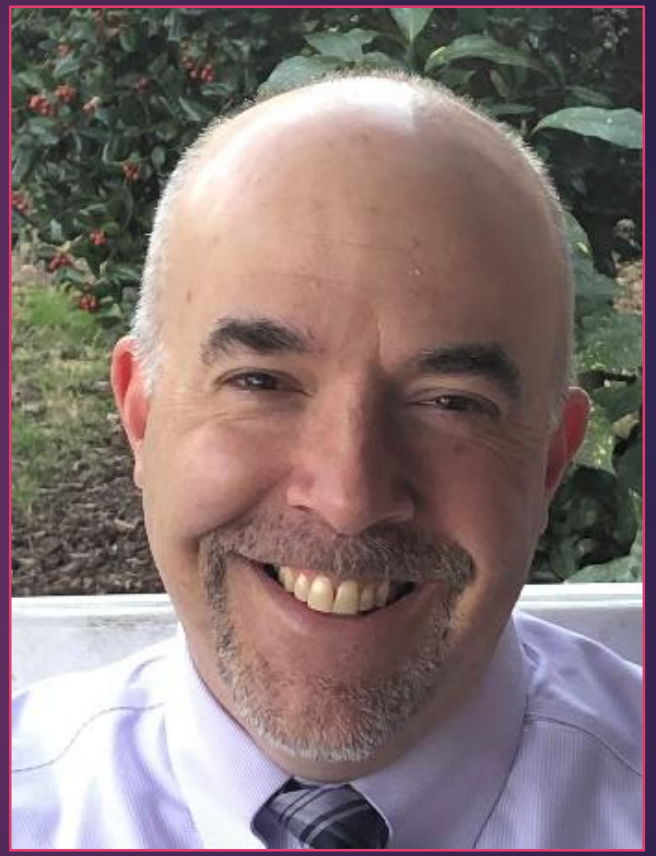
Hamilton Relay Transcriber (CC)

- The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings
- We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars
- The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat

Today's Presenter

Paul Brasler, MA, MSW, LCSW
Behavioral Health Addiction Specialist, DMAS

Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.



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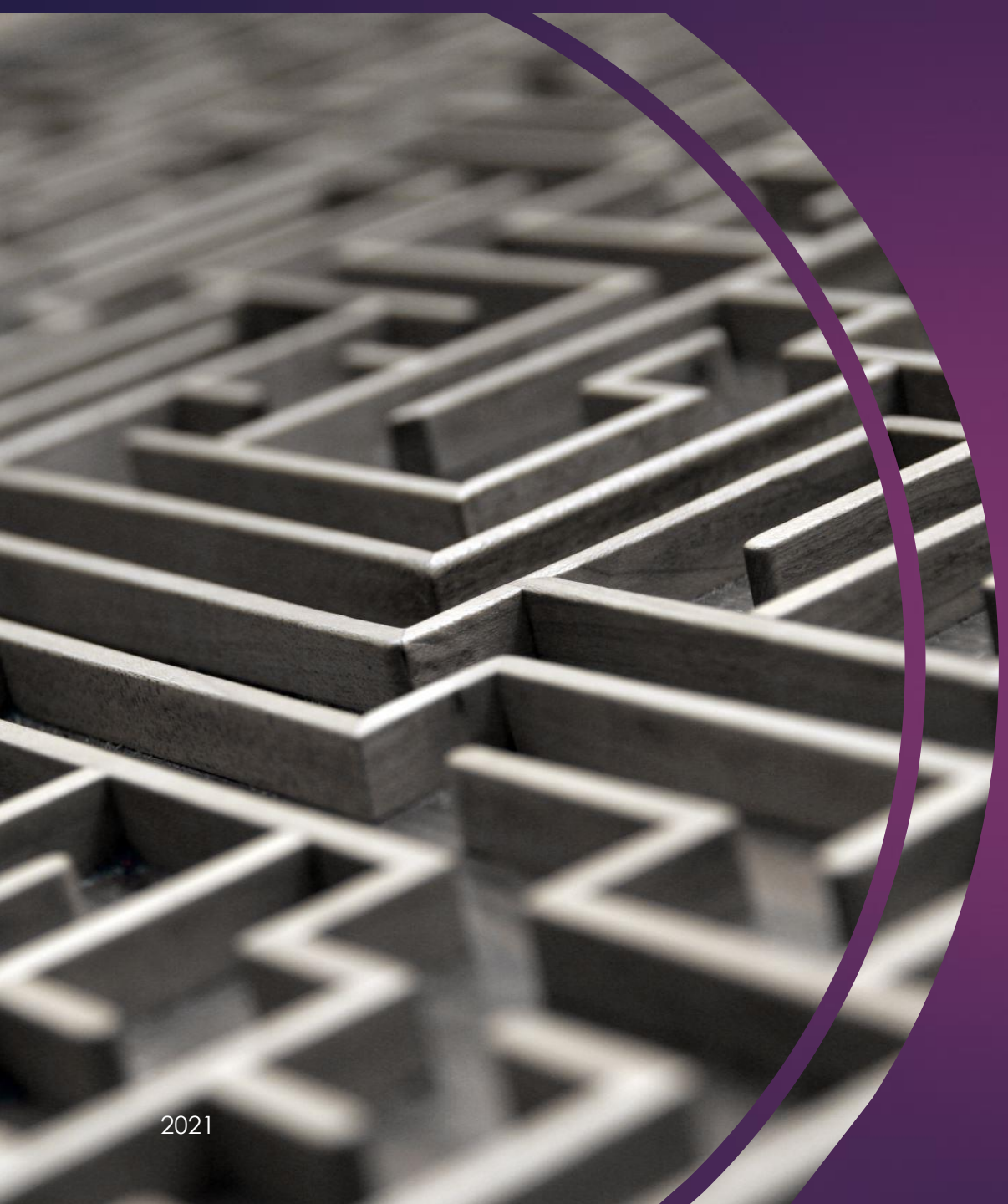
Addiction Defined: ASAM

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019



"A successful **addiction treatment program** is one that offers a wide range of evidence-based treatments backed by rigorous scientific studies, without unnecessary legal and institutional barriers, without stigma, in a client-centric manner"

(Andraka-Christou, 2020, p. 11)

Substance Use Disorders

Many plants and chemicals have properties that create an affinity for neuro-receptors, typically mimicking existing neuro-transmitters. Depending on the individual, their environment, and the chemical in question, this process can create a response called Substance Use Disorder (or addiction)

SUD Symptoms:

- Taken in larger amounts and longer than desired
- A lot of time is used to obtain, use and recover from the drug's effects
- Unsuccessful attempts to stop
- Failing to fulfill major responsibilities
- Continued use despite many problems in nearly all areas of life
- Continued use in dangerous situations
- Continued use despite medical and mental health problems that the client admits are due to drug use
- Cravings
- Tolerance
- Withdrawal symptoms

Why Do People Misuse Drugs?

1. Throughout human history, people have used a wide variety of plants and other chemicals to alter their mood, perception and behaviors
2. Some people may have a predisposition toward addiction
3. Some people live in environments where there is a high concentration of drugs or accepted (encouraged) use of substances
4. Some people use drugs that are socially acceptable
5. Others may use chemicals to address unrecognized mental or medical issues
6. Most people start using drugs because **it initially makes them feel good!**

Traditional Paths to SUD

"Denny"

- Upper-middle class background
- Raised by two parents
- No history of family violence
- Both grandfathers were alcoholics
- Started drinking as a teen, progressed to heroin by 19
- Numerous opportunities and attempts at treatment
- Family remains supportive and concerned throughout
- Died of a heroin overdose at age 23

"Ashley"

- Low socio-economic background
- Raised by a single mother; father not identified
- Extreme family/domestic violence
- Molested at age 7 by mother's boyfriend, raped at age 11 by uncle
- Started smoking marijuana by 12, progressed to heroin by age 20
- Jailed for prostitution and drug possession, no offers of treatment
- Stuck in a sexually-abusive situation for housing and money for drugs

A Newer Path to SUD

"Shirley"

- No history of any substance use
- Work-related back injury in 2007
- Prescribed OxyContin by Primary Care Provider for pain
- Tolerance develops, so dosage is increased
- Medical provider becomes concerned about possible dependence, so dosage is decreased
- Shirley starts running out of medication early and starts to purchase illicitly (~$1.00 per mg on the street)
- She soon realizes that heroin is cheaper, and stronger, so she starts to purchase it instead

Recovery Defined

"…the essence of recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal of being in ongoing quest for a better life."

(Best & Laudet, 2010 as cited in Morgan, 2019, p. 191)

Neurobiology of SUD

How Do Drugs Get to the Brain?

Pharmacodynamics: A drug's effect on the body

Pharmacokinetics: The body's effect on a drug; how a drug is absorbed, distributed, metabolized, eliminated and excreted by the body; all of which are influenced by:

- Route of administration
- Speed of transit to the brain
- Rates of metabolism
- Process of elimination
- Affinity for nerve cells and neurotransmitters

Pharmacodynamics & pharmacokinetics co-occur

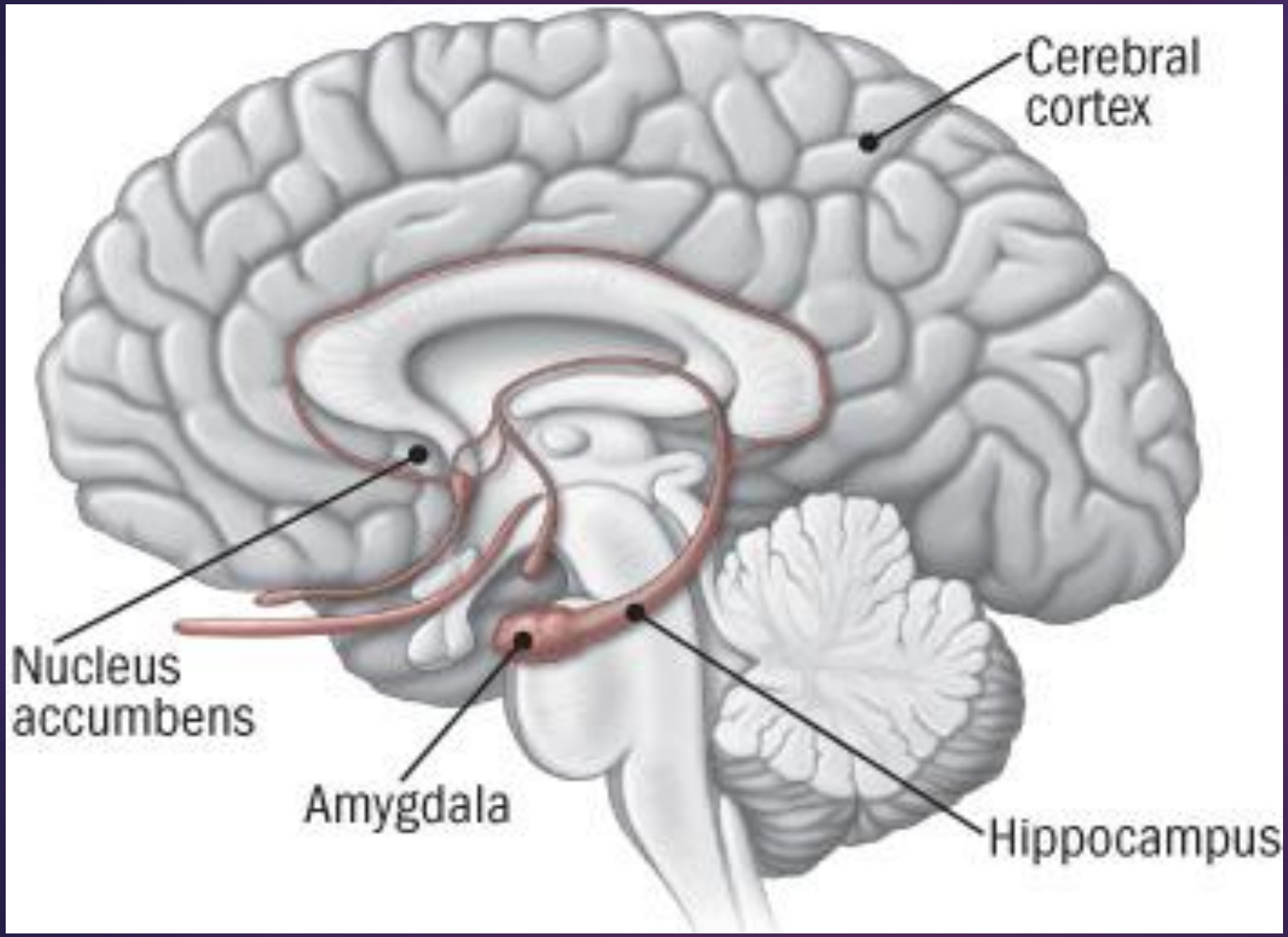
The more rapidly a drug reaches its target in the brain, the greater the reinforcing potential

Routes of Use

- **Inhalation**: The quickest way to the brain (7 – 10 seconds)
- **Injection**: The most dangerous and efficient method, as it bypasses the body's natural defenses
  - Intravenously (15 – 30 seconds)
  - Intramuscularly (3 – 5 minutes)
  - Subcutaneously (skin popping; 3 – 5 minutes)
- **Mucous Membrane Absorption**: (10 – 15 minutes)
  - **Insufflation** (snorting through the nose)
  - **Sublingually** (under the tongue) or **Buccally** (between gums & cheek)
  - Rectum or vagina
  - Eyeball
- **Oral Ingestion:** The drug is absorbed by the stomach or small intestine (20 – 30 minutes)
- **Contact Absorption:** Passive absorption through the skin (up to 7 days, but can take up to 2 days for full effect)

Drug Distribution & General Effects

- Once into the bloodstream, the drug will be distributed to the rest of the body
- The amount of the drug that reaches the brain depends on the drug's **bioavailability** (the degree to which a drug becomes available to target tissues after use)
- Once in the blood stream, the drug reaches the **blood-brain barrier** in 10 – 15 seconds
- The blood-brain barrier consists of capillaries which have tightly sealed epithelial cells that allow only certain substances (particularly fat-soluble) to cross the barrier



Addictive drugs provide a shortcut to the brain's reward system by:

1. Flooding the **nucleus accumbens** with dopamine
2. The **hippocampus** lays down memories of this rapid sense of satisfaction
3. The **amygdala** creates a conditioned (anticipated) response to certain stimuli

Substance Intoxication & Withdrawal Syndromes

While substance dependence/addiction is a chronic condition, **substance intoxication syndromes** and **substance withdrawal syndromes** have their own symptom sets, and in some cases, require immediate attention

Substance Intoxication

- "Intoxication refers to the immediate effects of the drug and occurs during consumption of a drug in a large enough dose to produce significant behavioral, physiological or cognitive impairments. It is these intoxicating effects that drive initial use. When drugs are consumed, a cascade or short- and long-term effects follows. Although some of the effects of intoxication are pleasant and desired, other effects can be aversive" (Filbey, 2019, p. 64)
- Some forms of intoxication require immediate medical treatment

Substance Withdrawal

- "Withdrawal is a negative state that occurs following cessation from use of a drug that has caused physical dependence. In other words, withdrawal most often occurs in those who have used a drug on a regular basis rather than occasionally" (Filbey, 2019, p. 81)
- Some forms of substance withdrawal (specifically alcohol, and other central nervous system depressants) may require immediate and ongoing medical attention to prevent further illness or death

Treatment: An Introduction

- Providing drug information alone to a person misusing drugs does not usually change their behaviors
- Scare-tactics have been shown to be ineffective in changing most people's behavior or drug use practices
- The earlier in life a person starts using substances, the greater the likelihood for Substance Use Disorder (SUD) to develop
- Likewise, the longer a person is in treatment, the greater the opportunity for recovery to occur and be sustained
- The longer the person maintains recovery, the better their long-term treatment outcomes will be

Treatment: An Introduction

- For many people with SUD, overcoming denial is one of the biggest obstacles to treatment
- Use of drugs often delays the user's emotional, and cognitive, development—typically at the age when the person starts using heavily
- Treatment should be tailored to address all aspects of the individual (cultural identification, ethnicity, sexual identity and gender expression, language, spirituality, etc.)
- Treatment should also be tailored to the drug type, amount used, frequency and length of time it was used

Treatment: An Introduction

People with SUD may engage and dis-engage in treatment during their illness; knowledge gained during treatment can be cumulative, therefore this back-and-forth pattern should not be viewed as treatment failure

Level of Care	ASAM LEVELS OF CARE: Description
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)
1.0	Outpatient Services (fewer than 6 – 9 hours per week): Includes OTPs, OBOTs, Individual, family and/or group counseling
2.0	Intensive Outpatient Services [IOP] (minimum of 3 hours per day; 6 – 19 hours per week). Typically group counseling, with some individual
2.5	Partial Hospitalization Services (minimum of 5 hours per day; 20 or more hours per week). Similar services to IOP
3.0	Residential/Inpatient Services. Usually about 30 days, and with varying levels of intensity and interaction with the outside community
4.0	Medically Managed Intensive Inpatient Services. Acute care settings for medically directed withdrawal management and related

Medically-Managed Intensive Inpatient Treatment

- **ASAM Level 4:** Hospital-based psychiatric stabilization
  - 24-hour medical care is at the core of the milieu
  - Necessary when the client is a danger to themselves or others because of medical and/or mental health issues
  - Can also apply to medical detoxification; often required for people who are dependent on alcohol or other CNS depressants
- This is typically a very short stay (less than a week), and usually precedes either residential treatment or partial hospitalization
- Longer stays may be necessary when dealing with severe mental illness, an inability to care for oneself (or remain safe), or in cases of protracted withdrawal symptoms requiring medical monitoring

Residential Treatment

- **ASAM Level 3:** Residential substance use treatment
  - Non-hospital-based settings
  - Usually between 28 – 90 days (but options and funding are often limited to much shorter stays)
  - Also different levels of service intensity
  - Should almost always be followed by aftercare services within the continuum of care
- Reif et al. (2014) found mixed results for residential treatment, recommending it be reserved for clients with severe co-occurring disorders, homeless individuals and/or clients who require a structured and contained environment to engage in recovery

The "Minnesota Model" of Residential treatment

- Inpatient treatment of ~28 days
  - Based on AA concepts, and usually focused on abstinence
  - Some programs may include MAT
  - Some programs have a strong medical component
- The focus is on the treatment milieu (the structure of each 24 hours):
  - Structure & Peer support
  - Education & Possible vocational training
  - Treatment (mainly group, possibly some individual)

Partial Hospitalization/Day Treatment

- **ASAM Level 2.5:** Typically 20 or more hours per week for 4 – 6 weeks
- Often used as a step-down from residential treatment and/or for people with significant co-occurring disorders
  - Can also be used as a "step-up" from IOP or as a substitute for residential treatment for some clients
- Heavily structured groups; may also include therapeutic recreational and experiential learning components
- Contains much of the content of a residential program (much of the time is spent in groups), but the client lives outside the program
- May incorporate MAT
- May also include a family component

Intensive Outpatient Programs

- **ASAM Level 2:** Typically 6 – 20 hours per week (most IOPs are ~9 hours per week) for 8 – 12 weeks
  - Like PHPs in that clients live outside the program
  - Usually three days per week; most of the time is spent in group therapy
  - Groups are structured with a mix of education, therapy, mindfulness exercises, and experiential learning
  - Family members can be involved in a weekly group session
  - Members may be encouraged to attend 12-step groups outside of the IOP
  - May include MAT
- Like partial hospitalization, can be used as a step-down/step-up to/from a more/less intense level of treatment or as a replacement for residential treatment
- A metanalysis by McCarty et al. (2014) found IOPs to be as effective as residential treatment for most clients

Non-Intensive Individual/Group Therapy

- **ASAM Level 1:** Individual and/or group therapy, 1 – 6 hours per week using a variety of therapeutic approaches
- There are several elements of effective individual/group psychotherapy:
  - Focus directly on the client's use of substances
  - Enhance motivation to change substance use
  - Develop coping skills to avoid substance use and make other lifestyle changes to support recovery
  - Changing reinforcement contingencies
  - Manage painful effects
  - Improve interpersonal functioning and social supports
  - Fostering the treatment alliance: Shared goals, tasks and emotional bonds

Therapeutic Communities

- Sometimes called "Recovery Houses" or "Sober-living communities"
  - Often utilized as a step-down from residential treatment, with many participants engaged in Day Treatment, IOP or outpatient treatment
- Many TC include the following elements (Herron & Brennan, 2015, p. 353 – 354):
  - Community Separateness from other programs
  - Community Environment (common spaces)
  - Community Activities
  - Staff are a mix of recovery-experienced and other helping professions
  - Day schedule is structured
  - Work is viewed as therapy; education opportunities are often present
  - Peers are role-models
  - Stays last around 12 – 18 months

Goal-Setting in Treatment

2021

Treatment should not be time-limited; the longer a person is in treatment, the greater the opportunity for recovery to occur and be sustained

Treatment should also be goal-focused, with goals determined by the client in consultation with the clinician

Goals should be:

- Measurable
- Realistic
- Flexible

Pharmacotherapy (Medication-Assisted Therapy)

Pharmacotherapy for Opioid Use Disorder

- Methadone and Buprenorphine (the active ingredient in Suboxone) are both opioids—human-made chemicals that are like opiates (medicines made from opium)
- Methadone was approved for opioid use disorder treatment in 1947 and Buprenorphine in 2002
  - Used for opiate withdrawal management in inpatient settings and maintenance treatment in outpatient settings
  - Given by a licensed provider and administered in oral form (an injectable form of buprenorphine is available)
- Behavioral health treatment is an important part of MAT, but clients should **not** be forced to receive counseling to be able to receive pharmacotherapy

Methadone & Buprenorphine Therapies

- Methadone and Suboxone act as opioid agonists: They keep the client from experiencing opioid withdrawal symptoms (also called "dope sickness") and block the euphoric effects should the client use heroin or another opioid, thus discouraging the client from continuing use
  - **Neither of these chemicals, when used as prescribed, will get the client high**
- However, methadone and buprenorphine are the most-regulated medicines in the U.S. when used for treating SUD
- Both chemicals allow the brain to heal from opioid use and provide opportunities for the client to address the underlying causes of their SUD

Methadone

- **Chemically unlike heroin or morphine, but works as an agonist for both**
  - Also used to treat chronic pain
- "Methadone has the strongest evidence base of any opioid addiction treatment" (Andraka-Christou, 2020, p. 52)
- Delivered in liquid or pill form in Opioid Treatment Programs (OTPs), sometimes call Methadone Clinics
- Long-term effects: 24 – 36 hours
  - This allows the client to work, attend school, parent, and engage in pro-social activities as opposed to purchasing, using and recovering from illicit opioid use
  - Responsible for some opioid overdose deaths, since Methadone accumulates in tissues before binding to plasma proteins
  - Withdrawal develops slowly and is prolonged when compared to morphine or heroin

Methadone

"Interviewees with methadone treatment experience argue that an appropriate methadone dose is critical to treatment success. Yet over 40 percent of U.S. methadone clinic patients receive too low a dosage, with nonwhite minorities particularly likely to receive insufficient doses. Significant evidence exists that methadone treatment programs should provide a minimum dose of 80 mg/day, as methadone dose is strongly related to treatment effectiveness." (Andraka-Christou, 2020, p. 134)

Buprenorphine

- An **opioid agonist** in low doses and an **antagonist** in high doses, often combined with Naloxone: Suboxone®
  - In this formulation, should the patient try to inject or insufflate the drug (instead of taking it orally), they will go into withdrawal symptoms (but people have found ways around this) (Kavanaugh & McLean, 2020)
  - Suboxone is delivered in a buccal film or pill
  - Less respiratory depression than Methadone
- Has a "ceiling effect" (at 32 mg) which makes overdose less likely—except when mixed with alcohol
- In 2017, the Food and Drug Administration approved Sublocade®, an injectable form of buprenorphine

Buprenorphine (Andraka-Christou, 2020, p. 44)

- "Buprenorphine has greater affinity for the brain's opioid receptors than other opioids, meaning it binds more tightly to the receptors, so it displaces other opioids already on the brain's receptors, after which it blocks the effects of subsequent opioids"
- "Even though buprenorphine has greater *affinity* for the opioid receptor, it actually has weaker intrinsic *activity* [italics in original] at the opioid receptors relative to methadone, meaning it creates less cellular activity, so people with OUD taking buprenorphine as prescribed are less likely to feel euphoria than people taking methadone as prescribed"

Barriers in Buprenorphine Treatment

- Not enough providers prescribing medication
- Stigma
- Concerns about diversion-related dangers (often inflated)
- Rigid program requirements (Jakubowski & Fox, 2020):
  - Abstinence as a treatment goal/No positive UDS
  - Must attend counseling (either before starting medication or to continue medication)

  (ASAM highly recommends same-day treatment access)
  - Must attend outside/peer-support groups

Naltrexone & Naloxone

These medications have antagonistic properties; they will cause an opioid user to go into withdrawal (Naloxone) if administered while the person is using opioids or will block the effects of opioids (Naltrexone)

- **Naltrexone** (Vivitrol®) is a deterrent, and is used to prevent relapse by limiting cravings
  - Also blocks the euphoric effects of opioids, cocaine, and alcohol
  - Time-release injectable versions and implant versions are available
- **Naloxone** (Narcan®) is injected or used intra-nasally to reverse an opiate overdose

Practice Recommendation

Clients who are using opioids, cocaine, methamphetamine, additional stimulants or any illicit substances should be provided with overdose prevention education AND either given or prescribed Naloxone and instructed how to use it

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